Mental Health System Transformation Initiative Implementation

Washington State
Department of Social & Health Services

STI Task Force Meeting

April 19, 2007

Washington State System Transformation Initiative

Update on Mental Health Benefits Design Project

Andrew Keller, PhD

April 19, 2007

Input Needed Today

- Input on promoting evidence-based culture
- Feedback on potential changes to Medicaid ACS
- Discussion of criteria used to prioritize Best Practices
- Discussion of current prioritization of Best Practices

Evidence-Based Culture

- Key components include:
  - ✓ Involves all levels of the system – state, regional, managers, clinicians
  - ✓ Begins with a thorough understanding of the current treatment system
  - ✓ Systematic approach to review available evidence, recommend changes
  - ✓ Supports a reimbursement rate commensurate with implementation
  - ✓ Provides reimbursement for needed training and clinical supervision
  - ✓ Data collection and reporting mechanisms to document EBP results
  - ✓ Develops policies to facilitate adoption/implementation of EBPs
  - ✓ Bi-directional communication between researchers and clinicians
  - ✓ Appropriate balance between fidelity and adaptation
  - ✓ Uses outcome data to drive systems change

Building an Evidence-Based Culture

- Input from the Task Force needed:
  - ✓ What current structures or processes at the state level support an evidence-based culture?
  - ✓ What structures or processes at any level currently get in the way of an evidence-based culture?

Proposed Change in the ACS

- Rationale for change
  - ✓ ACS add front-end limitations beyond those of the other leading managed care states we have reviewed (functional requirements)
  - ✓ This shifts focus of care away from earlier intervention
  - ✓ ACS generally seen by stakeholders to create bureaucratic burden with little benefit
  - ✓ Other states and private MCOs have generally relaxed functional access standards for initial and low level outpatient care
    - Eliminate prior authorization for such care (first 6-10 sessions)
    - Cost-effective: Any increase in service use more than offset by: (1) savings through early intervention and (2) reductions in the cost of managed care oversight
  - ✓ Most states we examined do exclude diagnostic groups (autism-spectrum without MH d/o) from behavioral waiver

Proposed Change in the ACS

- Preliminary recommendations
  - ✓ Focus only on Medicaid ACS
  - ✓ Separate eligibility from medical necessity
  - ✓ Focus eligibility on diagnosis, not functioning
  - ✓ Have just one diagnosis list (collapse A and B structure – too cumbersome)
  - ✓ Develop statewide medical necessity standards
    - Expand current level I and II to track by levels of care (eg, Routine OP, Extended OP, High Intensity Treatment, Day Treatment, Inpatient, etc.)
    - Transition from ACS should be RSN by RSN, rather than all at once
    - Should we include option of RSN-level flexibility?
  - ✓ In next waiver replace ACS with (1) list of covered diagnoses and (2) statewide LOC guidelines

Proposed Change in the ACS

- Change appears to be allowable now, under current waiver
  - ✓ ACS: "Access . . . is based on clinical assessment, medical necessity and individual need."
  - ✓ ACS: "The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need."
- Request for Feedback: What do you think of this?

Criteria for Prioritizing Best Practices

- Primary goals:
  - ✓ Biggest clinical impact (with emphasis on appropriate inpatient utilization)
  - ✓ Promotion of recovery and resilience
  - ✓ Promotion of culturally relevant practices and cultural competence
  - ✓ Promotion of consumer/family-driven care
  - ✓ Distribution across age groups
- Additional goals:
  - ✓ Widest and most immediate possible impact
  - ✓ Prioritize five, but promote as many best practices as possible
  - ✓ Potential cost-savings
- Discussion Topic: What did we leave out?

Approach to Prioritizing Analysis of Best Practices

- 50 practices (including variants) were sorted into five categories:
  - ✓ No analysis because Best Practice already sufficiently supported
  - ✓ Comprehensive cost analysis for statewide promotion (5 emphases)
  - ✓ Benefit design change analysis to support local promotion (analysis of waiver and service encounter reporting manual)
  - ✓ Benefit coding analysis to support local promotion (analysis of possible changes to service encounter reporting manual)
  - ✓ Not prioritized for further analysis
- Discussion Topic: What is your reaction to the draft prioritization matrix?

Washington State System Transformation Initiative:
Review of Involuntary Treatment Laws

April 19, 2007

Jenifer Urff, J.D.
Advocates for Human Potential, Inc.

Key Preliminary Findings

Most stakeholders agree that:

- Use of civil commitment reflects a lack of appropriate, recovery-oriented services in the community
- Actual statutory language has less impact on the use of civil commitment than other factors, especially the lack of housing and community residential options
- Most important statutory issue is definition of “mental disorder” because it results in the civil commitment of people who are not appropriately served in the mental health system
- Statute should not be narrowed unless adequate alternatives are available for people who would be affected

Definition of "Mental Disorder"

Wash. Rev. Code 71.05.020(22):

> "Mental disorder" means ***any organic, mental, or emotional impairment*** which has ***substantial adverse effects*** on a person's ***cognitive or volitional*** functions.

Questions for Discussion

- What populations currently are being civilly committed under §71.05 but would be better served in other settings?
- Why would they be better served in other settings?
- Why are they currently being served in psychiatric inpatient settings?
- What services/settings/processes would need to be in place in order for you to support a more narrow statutory definition of “mental disorder”?

Voluntary vs. Involuntary Status

- DMHPs may petition for an initial detention only if they have attempted to interview the person to determine if he or she will receive evaluation and treatment voluntarily (RCW §71.05.150)

- 14-day petitions may be filed only if "the person has been advised of the need for voluntary treatment and the professional staff of the facility has evidence that he or she has not in good faith volunteered" (RCW §71.05.230)

Questions for Discussion

- Are some individuals “involuntarily” treated even though they might be willing to receive treatment voluntarily?
- If so, what factors contribute to this?
- What are the implications of current policy? Conversely, what would be the implications of policies that might result in more conversions to voluntary status?

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Mental Health Housing Plan

STI Task Force Meeting

April 19, 2007

Prepared by:

Common Ground

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Housing Unit Goals

2007-2010: 600-800 Units

2010-2015: 1200-1600 Units

Subpopulation Mix

- Homeless: 65% (duplicated #)
- Adult (not Senior): 70%
- Senior: 10%
- Family: 20%

Mix of New & Existing Units

2007-2010: 60% New

40% Existing

2010-2015: 65% New

35% Existing

Financing Assumptions

2007-2010: Goals met with current resource levels

2010-2015: Goals require new $; more state and local partnerships

Geographic Priorities

- **Larger Population RSNs**
  - **King**
  - **Pierce**
  - **NorthSound**
  - **Greater Columbia**

+

Geographic Priorities

- **PACT RSNs:**

  previous slide plus

  - **Chelan Douglas**
  - **Spokane**
  - **Clark**
  - **Peninsula**

Capacity to Deliver

- MH Providers
  - New Units
  - Existing Units
- Private Landlords
- Public Systems
- Training/TA Priorities

Washington State
System Transformation Initiative

PACT Implementation
Task Force Update

April 19, 2007

Maria Monroe-DeVita, Ph.D.
The Washington Institute for Mental Illness Research & Training
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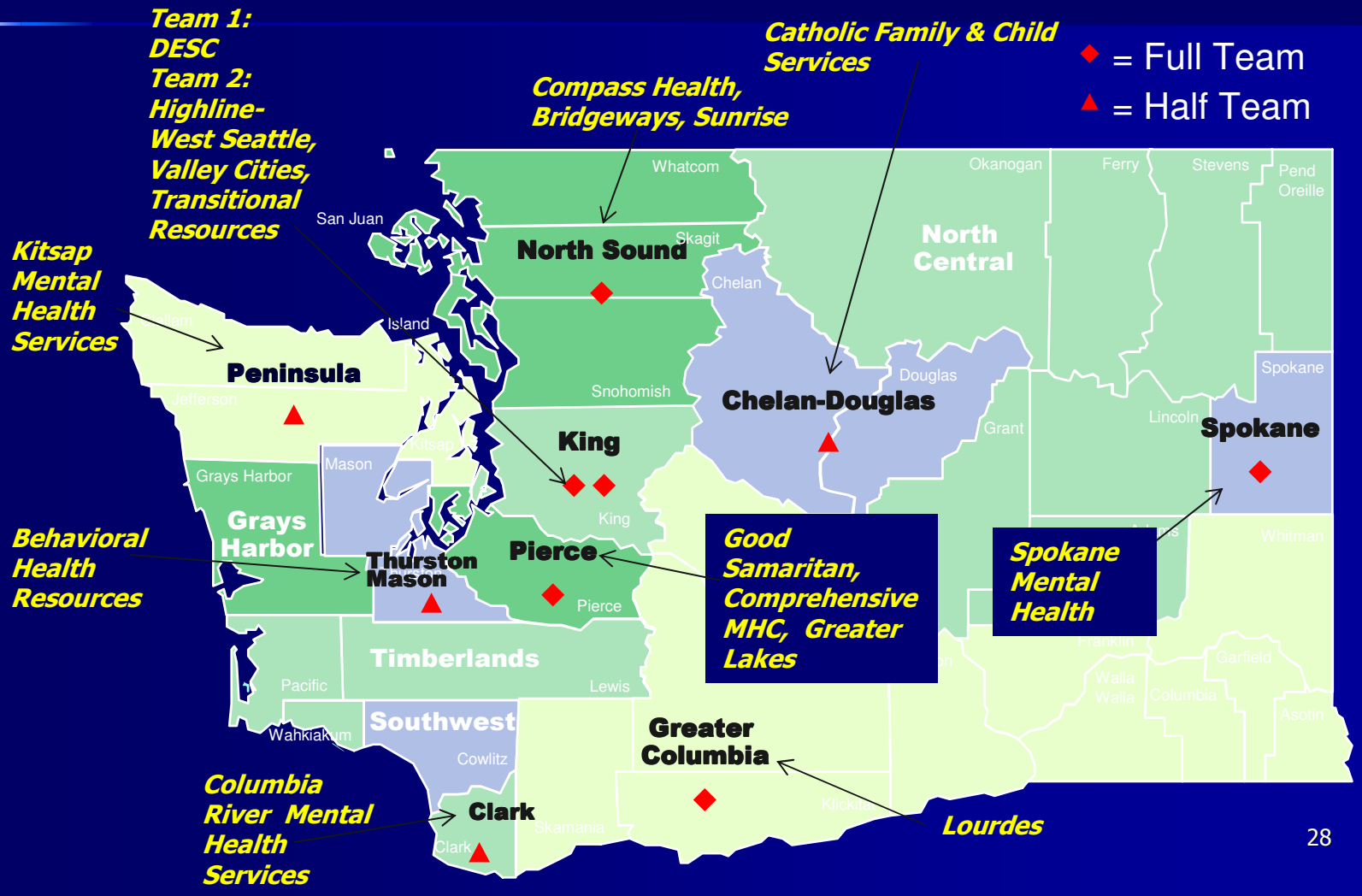
Update Overview

1. Update on current PACT implementation

2. Feedback on new program fidelity items

WA-PACT RSNs & Selected Providers



Status of WA PACT Implementation Today

- Western PACT providers in process of staff recruitment for each team
  - MHD distribution of PACT job links
- MHD contracts with RSNs completed
- WA-PACT Standards close to finalization
- WA-PACT Policy & Procedure Guidelines to be distributed

What's Next

- Continued TA for both Western and Eastern RSNs and providers
- Training, Training, Training
  - Team Leader Webcast Training
  - Oklahoma PACT Team Site Visits
  - Individualized Onsite Training (with each team)
  - Series of Modules in Core Areas, for example:
    - Strengths-Based Assessment/Person-Centered Planning
    - Motivational Interviewing for Engagement & Treatment of Co-Occurring Disorders
    - Housing Issues – Working with Landlords

PACT Fidelity Assessment Measure Development

The Value of Program Fidelity

...the extent to which program practices adhere to the principles of the intended program model

- Critical for replication
- Essential for true interpretation of outcome
- Helps to identify/prevent model drift
- Useful for performance improvement & supervision

What do we know about the value of PACT fidelity?

- Consumers and staff in PACT programs with *greater* fidelity experienced *better* outcomes

- McGrew & colleagues (1994) found that reduced hospital use was correlated with:
  - Shared caseloads
  - Nurse on team
  - Daily team meetings
  - Team leader as practicing clinician
  - Total contacts

More about PACT fidelity

- McHugo & colleagues (1999) examined consumer outcomes in 7 PACT teams
- Consumers served by high fidelity PACT teams experienced:
  - Fewer hospitalizations
  - Fewer treatment dropouts
  - Greater remission from substance use

The DACTS

(Teague et al., 1998)

- Assesses 28 domains
- Examines structure, staffing, organizational components, and nature of services
- Anchored ratings between 1 (“not implemented”) and 5 (“fully implemented”)
- Ratings based on *current* activities and status
- Completed by external reviewers or internal agency or team

DACTS Example Item

Domain	1	2	3	4	5
Responsible for Crisis Services	Not responsible for handling crises after hours	Emergency service has program-generated protocol	Program available by phone; consult role	Program provides emergency service backup	Program provides 24-hour coverage

Limitations of the DACTS

- Mainly assesses structure vs. processes or principles within the team
- Original purpose to assess a COD-ACT team
- Doesn't match up with National PACT Program Standards (i.e., WA-PACT Standards)
- Includes virtually nothing about person-centered, recovery-oriented processes

Approach to WA PACT Fidelity Assessment

- Use the DACTS template and approach
  - Utility in using an anchored scale vs. “is it there or not” approach
  - Much about the existing DACTS is useful
  - Many other states still use the DACTS -- only scale out there
- Crosswalk WA-PACT Standards with DACTS
  - Modification to some domains/anchors on staffing
  - More clarity in domains identified as problematic

Approach to WA PACT Fidelity Assessment

- Add items related to core PACT processes and recovery orientation
- Tap a broader range of perspectives
  - Consumers
  - Natural supports
- Use for ongoing performance improvement and supervision

Contextual Considerations

- Parallel assessment of PACT implementation (i.e., evaluation of factors key to successful implementation)
- Some overlap with outcome assessment, especially recovery indicators
- Balance trade-off between more essential info vs. increased time/burden

Strengths-Based Assessment

(Tondora & Davidson, 2006)

- A discussion of strengths is a central focus of every assessment; perceived deficits are interpreted within a strengths/resilience framework
- Language is in the consumer's own words
- Includes assessment of areas not traditionally considered "strengths" (e.g., most significant or most valued accomplishments, ways of relaxing or having fun, ways of calming down when upset, personal heroes, etc.)
- The diversity of strengths that can serve as resources for the individual are respected

SBA1: STRENGTHS ARE ASSESSED FOR ALL INDIVIDUALS

	1	2	3	4	5
Definition: A discussion of strengths is included in every medical record.	Less than 60% of charts reviewed include an assessment dedicated to the exploration of strengths.	60% of charts reviewed include an assessment dedicated to the exploration of strengths.	70% of charts reviewed include an assessment dedicated to the exploration of strengths.	80% of charts reviewed include an assessment dedicated to the exploration of strengths.	90% of charts reviewed include an assessment dedicated to the exploration of strengths.

SBA2: DIVERSITY OF STRENGTHS ASSESSED

Definition: Strengths in the following categories are explored and included in the assessment: talents, personal traits, familial resources, or neighborhood or community assets, spirituality and faith, knowledge gained from work roles, knowledge gained from parental roles, family stories and narratives, cultural knowledge and lore, knowledge gained from dealing with adversity, and hopes and dreams for future.	1	2	3	4	5
	Less than 60% of assessments identify strengths in more than 3 categories.	60% of assessments identify strengths in more than 3 categories.	70% of assessments identify strengths in more than 3 categories.	80% of assessments identify strengths in more than 3 categories.	90% of assessments identify strengths in more than 3 categories.

SBA3: STRENGTHS INFORM TREATMENT PLAN

	1	2	3	4	5
Definition: Strengths and resources that are identified in the assessment are reflected in the goals, action steps, or summary of the treatment plan.	Less than 60% of treatment plans incorporate a strength/ resource as identified in the assessment.	60% of treatment plans incorporate a strength/ resource as identified in the assessment.	70% of treatment plans incorporate a strength/ resource as identified in the assessment.	80% of treatment plans incorporate a strength/ resource as identified in the assessment.	90% of treatment plans incorporate a strength/ resource as identified in the assessment.

Person-Centered Planning

(Tondora & Davidson, 2006)

- Staff actively partner with the individual in all planning meetings regarding his/her recovery services & supports
- Goals are based on the individual's unique interests, preferences, and strengths; objectives and interventions are clearly related to attainment of these stated goals
- A wide range of interventions & contributors to the planning process & services are recognized & respected
- Community inclusion/integration is valued as a commonly identified & desired outcome

PCP1: ROLE OF CONSUMER IN PLAN DEVELOPMENT & PLANNING MEETING

	1	2	3	4	5
Definition: The primary direction in the planning process comes from the individual consumer and/or his/her family/natural supports.	There is no meeting focused on plan development. Plan is developed in advance by program staff, and is given to consumer for signature. Less than 50% of plans include consumer signatures.	There is no meeting focused on plan development. Plan is developed in advance by program staff, and is given to consumer for signature. Over 50% of plans include consumer signatures.	Program staff take responsibility for planning and facilitating (see note) a meeting. Plan structure does not directly solicit consumer's current level of satisfaction across a broad range of life areas. The consumer speaks minimally in the meeting. Plan is written only in professional language, and does not include the individual consumer's own words.	The consumer's preferences drive decisions re: planning and facilitation of a meeting. Plan structure directly solicits consumer's current satisfaction in a broad range of life areas, and it allows the individual to rate priority-level of each. The individual actively contributes to the discussion in the meeting, and his/her own words are reflected in the document.	In addition to (4), the program provides necessary support to promote self-direction and leadership in person-centered planning meetings (e.g., offering peer-based coaching and/or skills-based training around the individual's role in person-centered planning).

PCP2: DIVERSITY OF PLAN GOALS

Definition: Person-centered plans address a diverse range of life areas (e.g., physical health, social relationships, employment/ education, spiritual life, housing satisfaction, community activities, empowerment and decision-making, etc.) in addition to clinically-defined treatment goals re: psychiatric symptoms or substance use.	1	2	3	4	5
	Less than 60% of charts reviewed include a diverse life goal which extends beyond clinically-defined treatment goals.	60% of charts reviewed include a diverse life goal which extends beyond clinically-defined treatment goals.	70% of charts reviewed include a diverse life goal which extends beyond clinically-defined treatment goals.	80% of charts reviewed include a diverse life goal which extends beyond clinically-defined treatment goals.	90% of charts reviewed include a diverse life goal which extends beyond clinically-defined treatment goals.

PCP3: CONSUMER ACCESS TO ASSESSMENTS & TREATMENT PLANS

	1	2	3	4	5
Definition: The consumer's access to, and review of, the person-centered planning document is facilitated and encouraged.	Program has no policy or procedure for consumers to obtain access to their assessment & treatment plan.	Program has policy for consumers to obtain access to their assessment & treatment plan but the procedure is overly complex or burdensome.	Program has policy for individuals to access their assessment & treatment plan and procedures are minimal. Consumers have limited knowledge of this procedure, and access is rarely requested.	In addition to (3), program encourages access by providing individual-level and program-level education re: rights and procedures for access to the assessment & treatment plan. Procedure is widely known to consumers, and access is regularly requested.	In addition to (4), individuals are *automatically* given a copy of their assessment & treatment plan. They are encouraged to make notes, additions, and edits for inclusion in the record. There is evidence in the chart that this process occurred, e.g., consumer signs-off on his/her receipt of plan or his/her choice to decline the offer.

Additional Fidelity Indicators Under Consideration

- Unbundling of Consumer Choice & Service Individualization from SBA & PCP
- Rural specifications, where indicated
- Roles of Key Staff & Specialists on Team
  - e.g., Team Leader, Vocational Specialist
- Specific services and processes
  - e.g., Active Recruitment, Supported Employment
- Active Stakeholder Advisory Group

Do these additional items generally capture important “ingredients” of a person-centered, recovery-oriented PACT team?

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Utilization Management Project

April 19, 2007 Report to Systems Transformation Initiative Task

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Overview of Purpose

- Review process and practice of UM in State and Community Hospitals by RSNs and MHD.
  - Focus on Medicaid and other publicly funded consumers served in Community Hospitals, voluntary and involuntary.
  - All consumers served by the State Hospitals.
- Compare and analyze practice across the RSNs and State Hospitals
- Develop options and recommendations for improvements

Key Activities to date

- Every RSN contacted and most interviews are completed
- ESH site visit completed
- Consumer focus group - Eastside
- Community hospitals surveyed
- Literature review in process
- Comparison State Review in process
- Data set being compiled

RSN Key Informant Interviews

Focus on three areas across the RSNs to find the best practices and areas of challenge.

- Utilization Management Processes
- Resources available in the various RSNs to provide alternatives to hospitalization.
- Data Collection by the RSNs

RSN Utilization Management Processes

Review of the Policy & Procedures of pre authorization for inpatient stays and continued stay review along with criteria used.

- "Best Practices"
- Challenges

ITA process review

RSNs ability to provide lesser restrictive options for consumers in the ITA

State Hospital access and usage for RSNs consumers

Consumer children and specialized processes

Other

RSN RESOURCES

Diversion or Discharge Options

Each RSN was asked specifically to comment on their ability to provide Lesser Restrictive options for the following:

- Pre-admitted voluntary Consumers
- Voluntary local inpatient Consumers
- Involuntary local inpatient Consumers
- Involuntary State inpatient Consumers
- Children in all of the above categories?
- Specialized services for consumers with complex needs (DD, TBI, Dementia, Long Term Care, Complex Medical.)

RSN Data Collection

- UM data collection tools
- Reporting of RSN UM data
- Best practices and areas of challenge
- Medical acuity or behavioral acuity measures (specific tools)

UM Suggestions from RSNs

RSN perspective of “pros and cons” of External UM processes

Suggestions for improvements to statewide processes and oversight of inpatient admissions

Question for Task Force

Suggestions for specific or other key contacts:

- Tribal Governments and representatives
- RSN and subcontractor key informant interviews
- Consumer focus groups at State Hospitals and in community settings
- NAMI and family members
- State/MHD staff
- State and Community Hospital staff

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